Missouri Statewide Health Information Exchange

HIE & HITECH Opportunities Overview

December 3, 2009
Jefferson City, MO

Definitions – ARRA & HITECH

ARRA
American Recovery & Reinvestment Act

$787 Billion federal stimulus package passed by Congress and signed by President Obama in February 2009.

HITECH Act
Health Information Technology for Economic & Clinical Health Act

Title XIII and Title IV of the ARRA, the section of the stimulus package focused on supporting the more widespread adoption of health information technology.

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Definitions – Health IT, HIE, and RHIO

HIT
Health Information Technology
Provides the umbrella framework to describe the comprehensive management of health information and its secure exchange between consumers, providers, government and quality entities, and insurers. Health IT (or HIT) in general are increasingly viewed as the most promising tool for improving the overall quality, safety and efficiency of the health delivery system.

HIE
Health Information Exchange

The electronic movement of health-related information among organizations according to nationally recognized standards.

RHIO
Regional Health Information Organization

A health information organization that brings together healthcare stakeholders within a defined geographic area and governs health information exchange among them for the purpose of improving health and care in that community.

Definitions – EMR, EHR, PHR

EMR
Electronic Medical Record

An electronic record of health-related information on an individual that can be created, gathered, managed and consulted by authorized clinicians and staff within one healthcare organization.

EHR
Electronic Health Record

An electronic record of health-related information on an individual that conforms to nationally recognized interoperability standards and that can be created, managed and consulted by authorized clinicians and staff across more than one healthcare organization.

PHR
Personal Health Record

An electronic record of health-related information on an individual that conforms to nationally recognized interoperability standards and that can be drawn from multiple sources while being managed, shared and controlled by the individual.

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Health Information Exchange

Current Confusion
Evolving and Competing Landscape
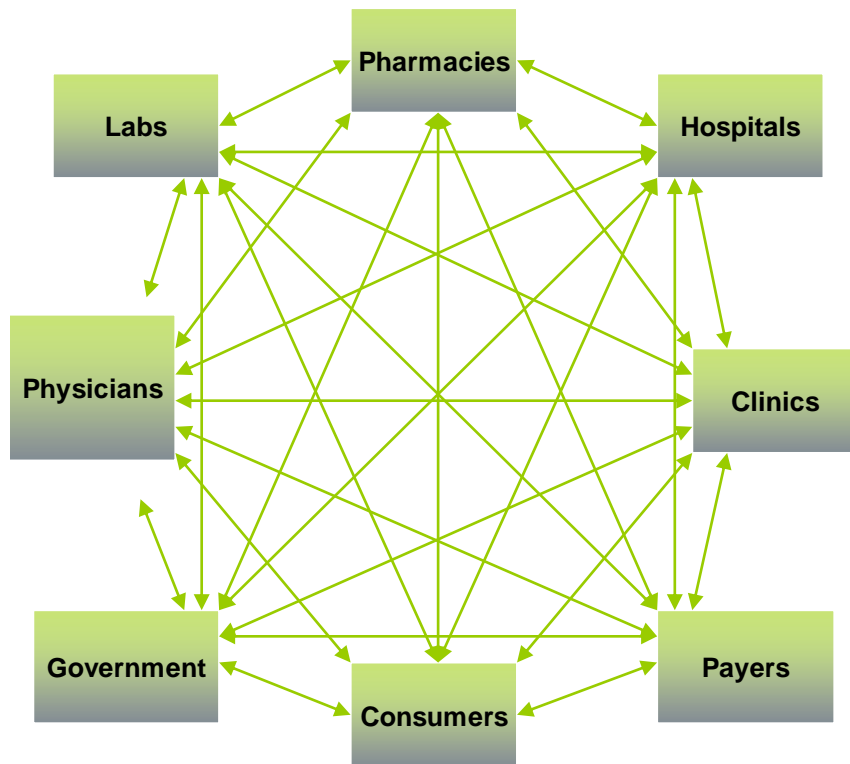
Future Vision
Improved Access and Use of Health Information
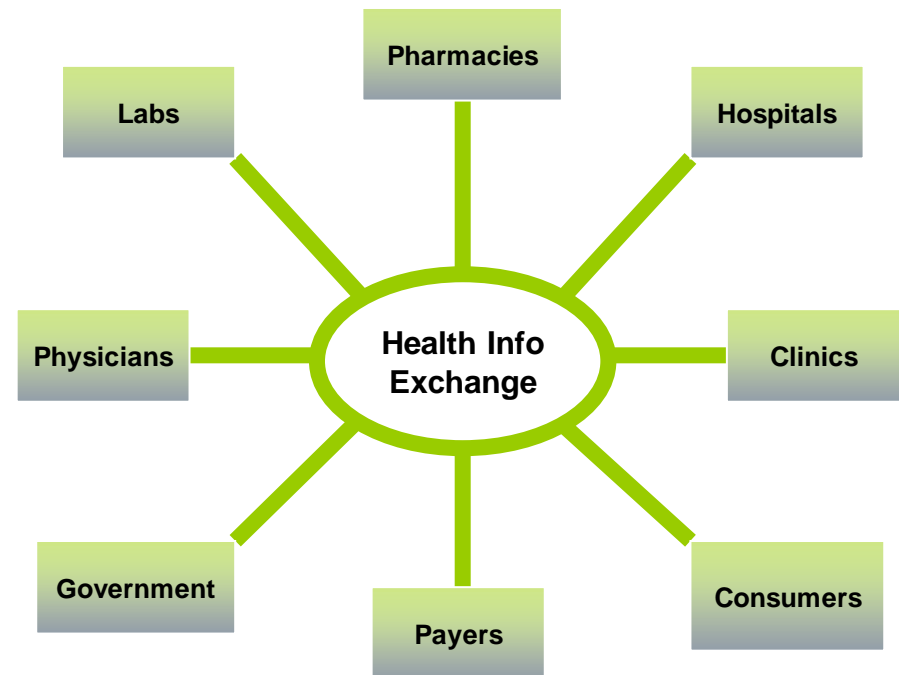
Health Information Technology – More than the Sum of its Parts

"It is one thing to get a computerized workstation onto a doctor's desk, but it is quite another to ensure that the computing capability and software make the providers smarter, more efficient, higher-quality clinicians."

D. Blumenthal, National Coordinator for Health Information Technology: "The Federal Role in Promoting Health Information Technology," 26 January 2009, http://www.commonwealthfund.org/publications/publications_show.htm?doc_id=792771

The federal vision for expanded health information technology adoption includes:

- Enabling data exchange that is **impactful** and supports **better coordinated care**
- Effectively **engaging patients** as participants in their own care plans; and
- Demonstrating their value through effective **public health reporting and quality reporting**

Federal Commitment to Health IT

New Incentives for Adoption

New Medicare & Medicaid payment incentives for HIT adoption

- $23+ billion in expected payments through Medicare to hospitals & physicians
- $21+ billion in expected payments through Medicaid
- $46.8 billion expected outlays, 2011-2016

Appropriations for HIE

$564 million for HIE development

- Funneled largely through States or qualified State-designated entities
- For planning and/or implementation

Appropriations for Health IT

$1.2 billion for loans, grants & technical assistance for:

- Regional Extension Centers ($598M)
- EHR State Loan Fund (possible)
- Workforce Training
- Research and Demonstrations
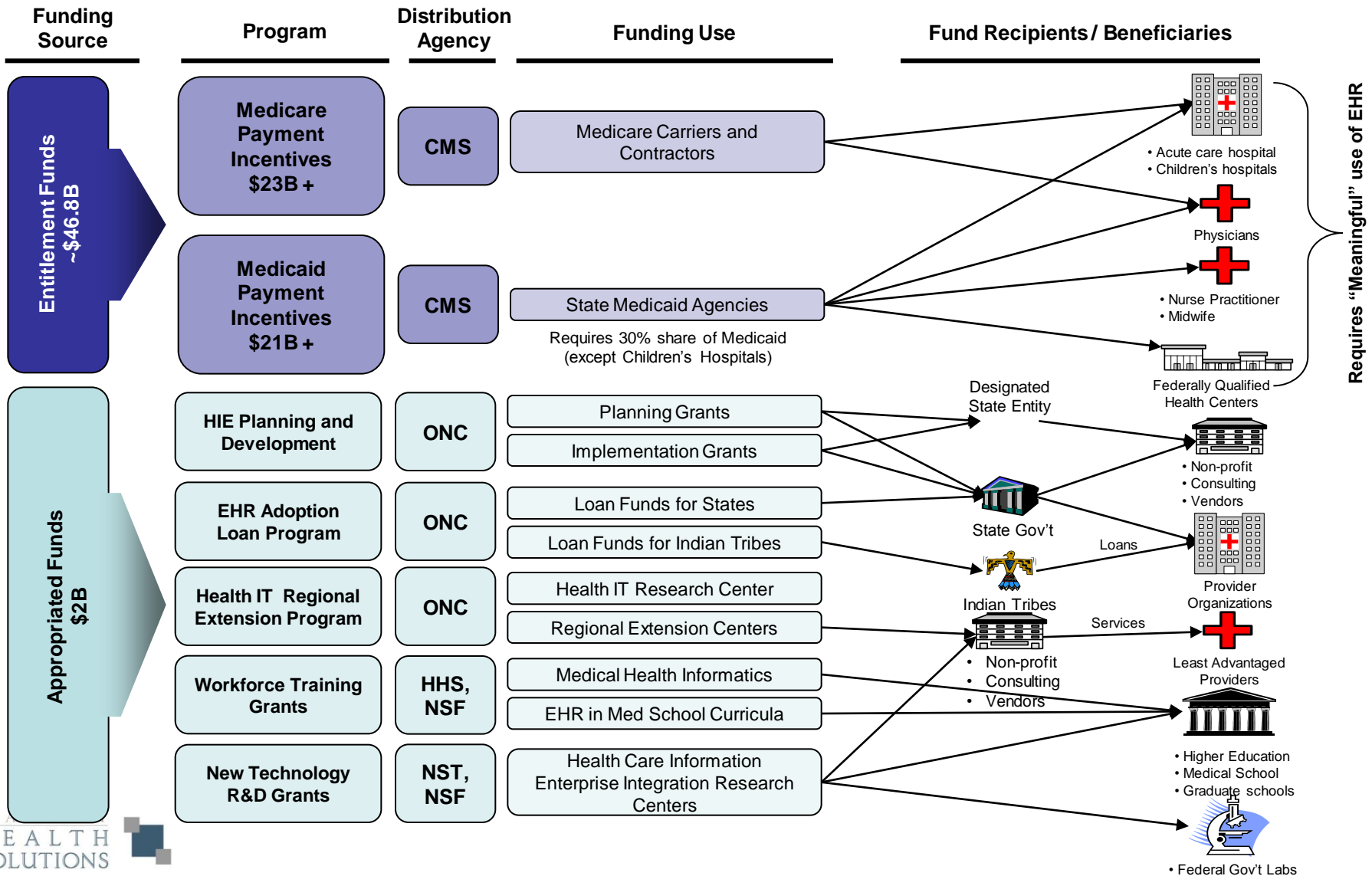
Broadband and Telehealth

$4.3 billion for broadband & $2.5 billion for distance learning/ telehealth grants

Workforce Development

Over $1 billion in workforce training and development funds from Department of Labor (DOL), Agency for Healthcare Research & Quality (AHRQ), and Office of the National Coordinator for HIT (ONC).

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$48+ Billion for Health IT
Majority Through Meaningful Use Incentives

Funding Source	Program	Distribution Agency	Funding Use	Fund Recipients / Beneficiaries

Entitlement Funds ~$46.8B

Program	Distribution Agency	Funding Use
Medicare Payment Incentives $23B +	CMS	Medicare Carriers and Contractors
Medicaid Payment Incentives $21B +	CMS	State Medicaid Agencies — Requires 30% share of Medicaid (except Children's Hospitals)

Fund Recipients / Beneficiaries:
- Acute care hospital
- Children's hospitals

Physicians

- Nurse Practitioner
- Midwife

Federally Qualified Health Centers

Requires "Meaningful" use of EHR

Appropriated Funds $2B

Program	Distribution Agency	Funding Use
HIE Planning and Development	ONC	Planning Grants / Implementation Grants
EHR Adoption Loan Program	ONC	Loan Funds for States / Loan Funds for Indian Tribes
Health IT Regional Extension Program	ONC	Health IT Research Center / Regional Extension Centers
Workforce Training Grants	HHS, NSF	Medical Health Informatics / EHR in Med School Curricula
New Technology R&D Grants	NST, NSF	Health Care Information Enterprise Integration Research Centers

Fund Recipients / Beneficiaries:
- Designated State Entity
- State Gov't
  - Non-profit
  - Consulting
  - Vendors
- Indian Tribes
  - Non-profit
  - Consulting
  - Vendors
- Provider Organizations — Loans
- Least Advantaged Providers — Services
- Higher Education
- Medical School
- Graduate schools
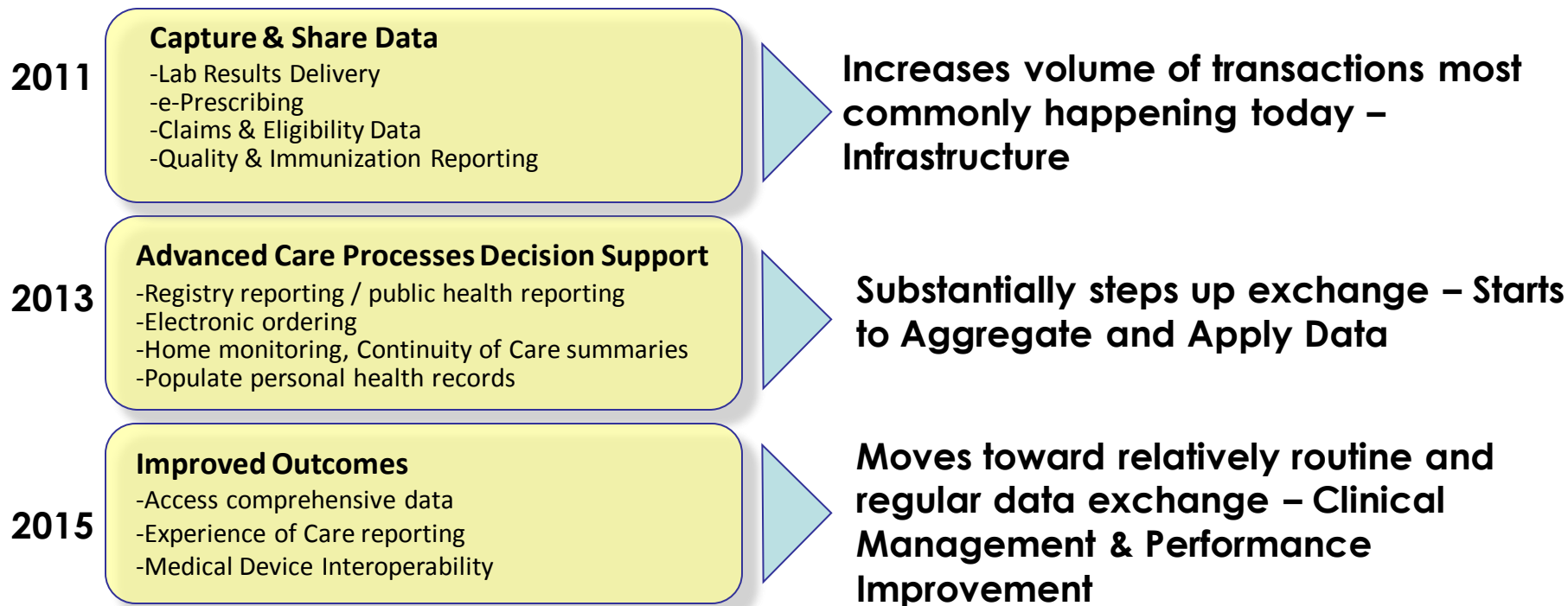- Federal Gov't Labs

Meaningful Use – EHR Incentives

Providers can draw down incentives by using certified EHR technology in a "meaningful manner," including:

1. Electronic prescribing**, to the "satisfaction of the Secretary"**

2. **Demonstrates "**electronic exchange of health information **to improve the quality of health care, such as promoting care coordination," to the satisfaction……**

3. Reporting on clinical quality measures **to the satisfaction….**

Meaningful Use

Vision of Meaningful Use

"To enable significant and measurable improvements in population health through a transformed health care delivery system."
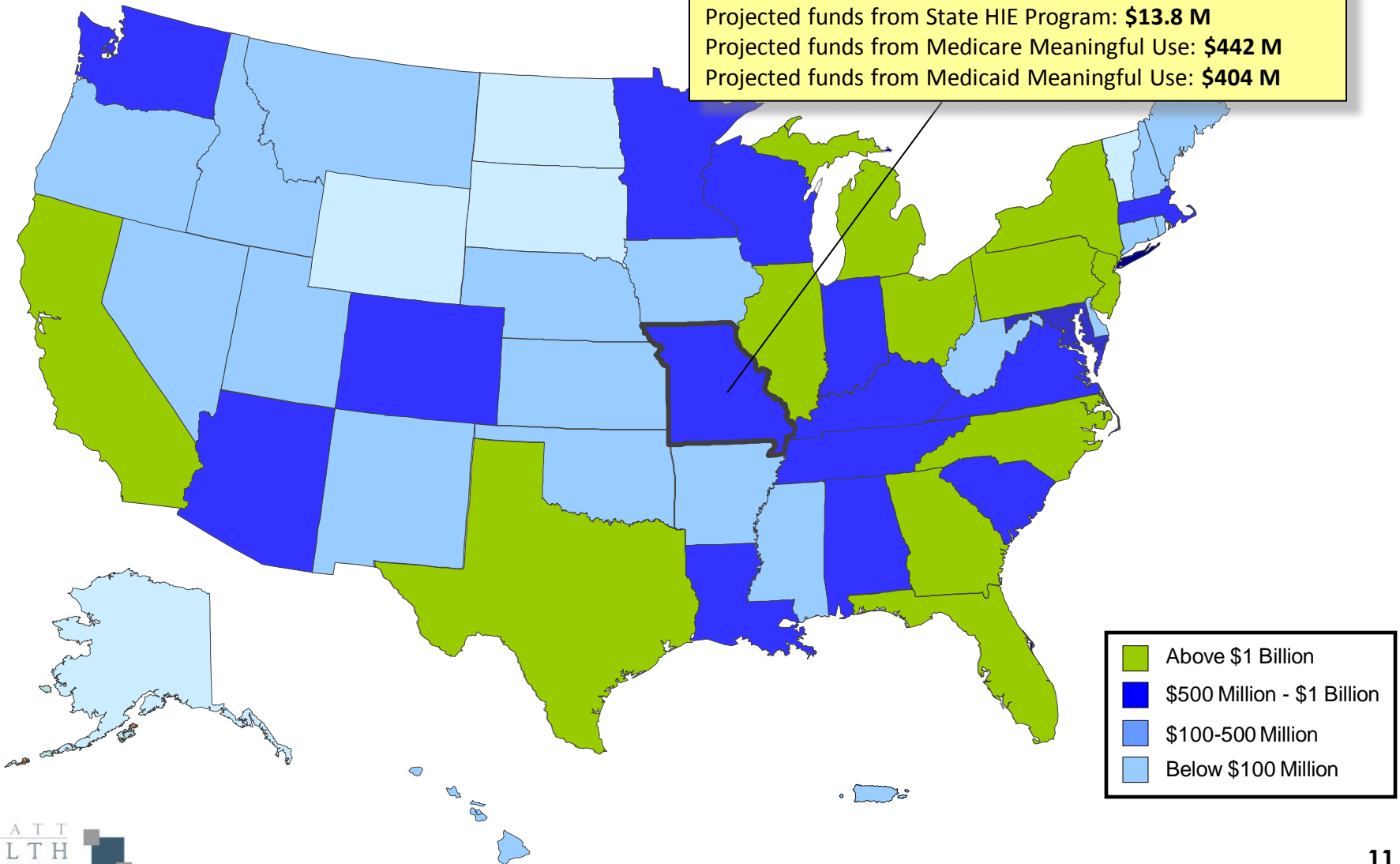
2011

Capture & Share Data
-Lab Results Delivery
-e-Prescribing
-Claims & Eligibility Data
-Quality & Immunization Reporting

Increases volume of transactions most commonly happening today – Infrastructure

2013

Advanced Care Processes Decision Support
-Registry reporting / public health reporting
-Electronic ordering
-Home monitoring, Continuity of Care summaries
-Populate personal health records

Substantially steps up exchange – Starts to Aggregate and Apply Data

2015

Improved Outcomes
-Access comprehensive data
-Experience of Care reporting
-Medical Device Interoperability

Moves toward relatively routine and regular data exchange – Clinical Management & Performance Improvement

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Estimated Meaningful Use Stimulus Funding by State

Missouri:
Projected funds from State HIE Program: **$13.8 M**
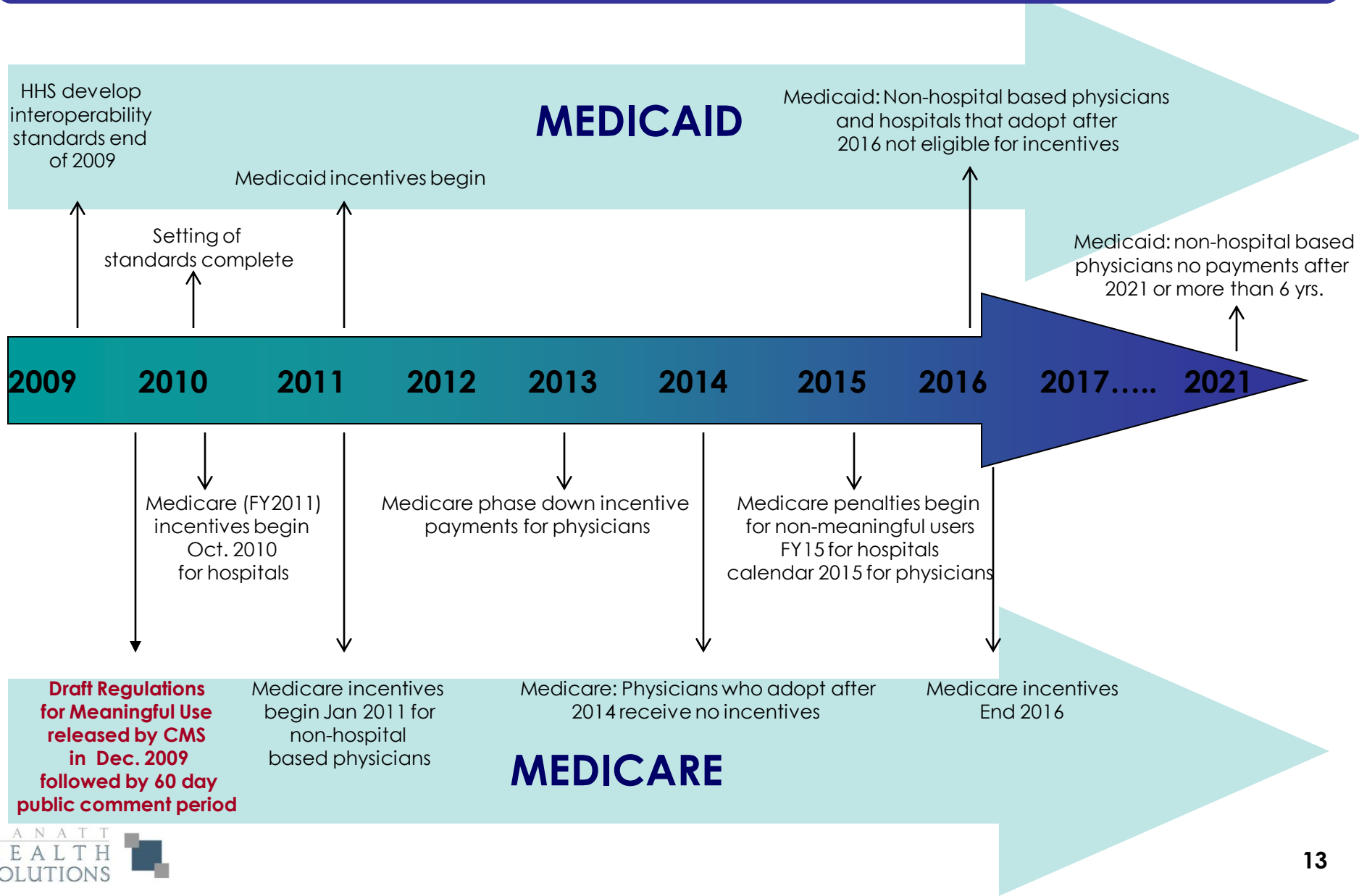Projected funds from Medicare Meaningful Use: **$442 M**
Projected funds from Medicaid Meaningful Use: **$404 M**

Legend:
- Above $1 Billion
- $500 Million - $1 Billion
- $100-500 Million
- Below $100 Million

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Medicare and Medicaid Incentives

	Medicare	Medicaid
Funding Mechanism(s)	Federal Incentive Payments	Federal Incentive Payments State matching payments (for admin costs)
Payment Agent	Medicare carriers and contractors	State Medicaid agencies
Payment Recipients	Hospitals and "Eligible Professionals" - Medicare program are non-hospital-based providers and limited to "physicians" as defined under Medicare statute, which includes Doctors of Medicine, Osteopathy, and Podiatric Medicine.	Hospitals and "Eligible Professionals" – Medicaid incentive program expands the definition of "Eligible Professionals" to include: Certified nurse mid-wives; Nurse practitioners; Physician assistants (under certain circumstances) and Dentists.
Amounts for Hospitals	*$2 million base amount* Plus increases for annual discharges, number of inpatient days attributable to Medicare, and charges attributable to Medicare Max of 4 years of payments, defined schedule	*$2 million base amount* Plus increases calculated using similar methodology as Medicare incentive *(eligible entities include Acute Care and Children's Hospitals)* Min of 3 yrs and max of 6 yrs of payments, State flexibility on schedule
Amounts for physicians & other health professionals	*Up to $44,000 in Medicare reimbursements* Over 5 year period	*Up to $64,000* Over a 6 year period covering up to 85% of eligible implementation costs
Timing	Incentives begin in Oct. 2010 for hospitals and Jan. 2011 for physician	Incentives to begin in 2011 for both hospitals and physicians.

Aggressive ARRA Funding Timeline

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HHS develop interoperability standards end of 2009

Medicaid incentives begin

Medicaid: Non-hospital based physicians and hospitals that adopt after 2016 not eligible for incentives

Setting of standards complete

Medicaid: non-hospital based physicians no payments after 2021 or more than 6 yrs.

2009 2010 2011 2012 2013 2014 2015 2016 2017….. 2021

Medicare (FY2011) incentives begin Oct. 2010 for hospitals

Medicare phase down incentive payments for physicians

Medicare penalties begin for non-meaningful users FY15 for hospitals calendar 2015 for physicians

Draft Regulations for Meaningful Use released by CMS in Dec. 2009 followed by 60 day public comment period

Medicare incentives begin Jan 2011 for non-hospital based physicians

Medicare: Physicians who adopt after 2014 receive no incentives

Medicare incentives End 2016

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State & Regional Initiatives

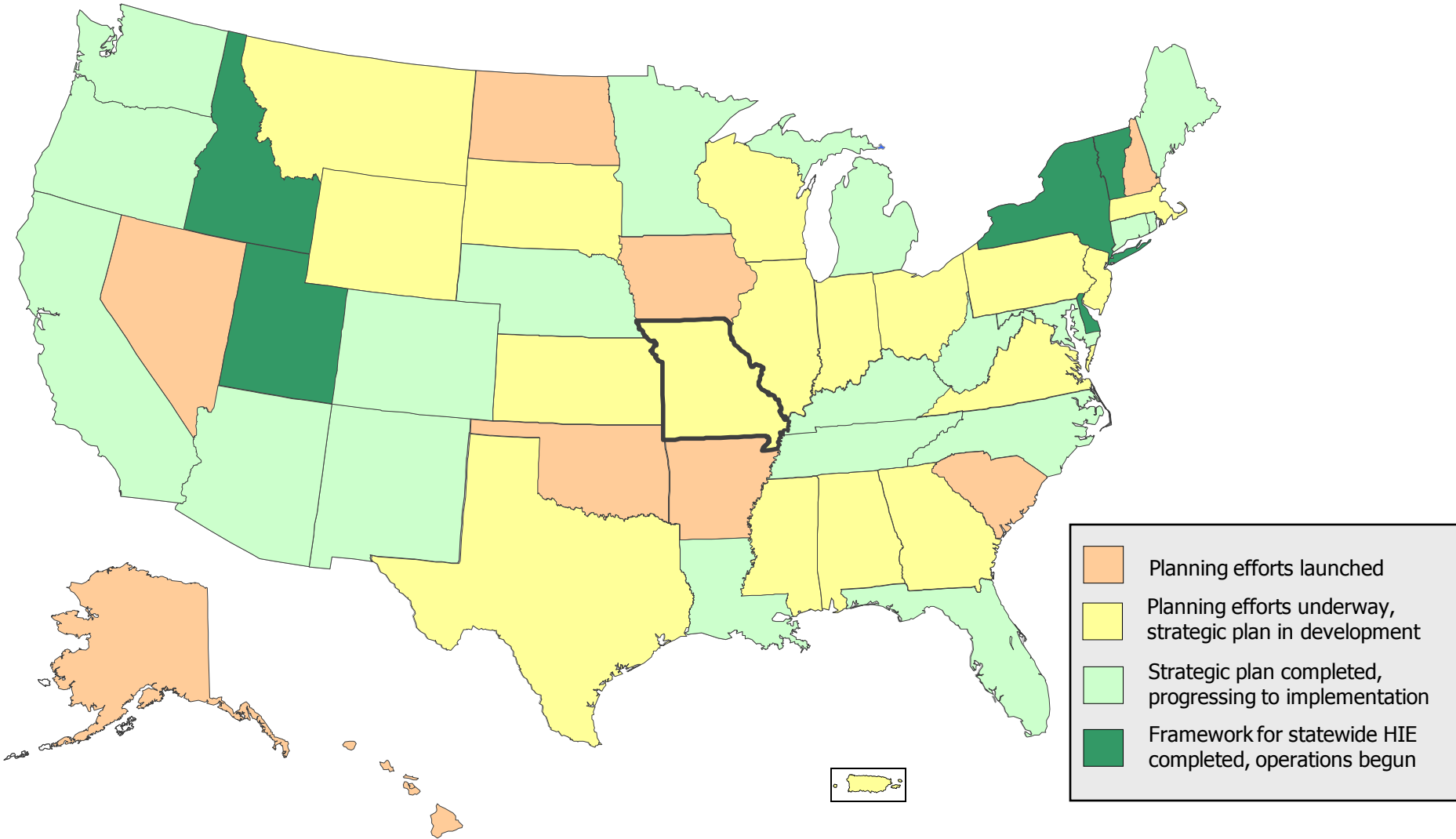| ITEM	AGENCY	STATUS
Medicaid Incentives	State Medicaid Agency	➢ States are eligible for federal match of 90% of administrative costs. ➢ States may draft their own definition of meaningful use for the Medicaid Incentives.
State Health Information Exchange Grants	State or state designated entity	➢ Applications due from states by October 16. ➢ Every state is eligible ($4-$40 million per state)
Regional Extension Centers	Non-for-profit entity covering a region that includes 1,000 primary care docs	➢ Two rounds of funding. Up to 70 RECs across the country covering non-overlapping geographic areas. ➢ Initial focus on supporting small physician primary care practices (10 docs or less).

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State HIE Program – Classification of States

ONC will evaluate States based on status of existing HIE activities

Category	Required State Actions
States with no existing Strategic Plan	➢ Provide a detailed description of activities to develop Strategic and Operational Plans by the application deadline ➢ Develop and submit initial Strategic and Operational Plans within 6 – 8 months of funding *States will engage in substantial "planning activities"*
States with existing Strategic and/or Operational Plans that *are not consistent* with ONC criteria	➢ Submit existing Plans with a detailed gap analysis compared to ONC's criteria and a plan for revision ➢ Submit updated Strategic and Operational Plans in alignment with ONC criteria within 3 months of funding *States are expected to move quickly from planning to implementation activities*
States with existing Strategic and/or Operational Plans that *are consistent* with ONC criteria	➢ Submit Plans for approval by ONC, including a description of health IT implementation to date and the plan for continued implementation *States will continue implementation activities*

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Statewide HIE Planning & Implementation
Estimated Status *Prior* to October 16th

Legend:
- Planning efforts launched
- Planning efforts underway, strategic plan in development
- Strategic plan completed, progressing to implementation
- Framework for statewide HIE completed, operations begun

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What States Have Been Doing – Same Goals, Differing Approaches

Goals

- Organize stakeholders, take inventory of resources and needs
- Develop statewide plan for federal funds and long term healthcare roadmap
- Develop plan for implementing Medicaid incentives

Sample Approaches to Statewide HIE

Idaho

HIE: A single statewide network, Idaho Health Data Exchange

Governance: Strong public-private collaborative framework.

New York

HIE: Local HIEs linked through common policies, technical specifications and shared services

Governance: Strong public-private collaborative framework.

Indiana

HIE: Multiple, independent local HIEs, no statewide architecture

Governance: Limited centralized authority.

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Resources

- **MO-HITECH Resources - http://www.dss.mo.gov/hie/**
  - Project Application & Narrative - http://dss.missouri.gov/hie/files/pca-project-narrative.pdf
  - Executive Order 09-27 - http://www.sos.mo.gov/library/reference/orders/2009/eo09_027.asp
  - FAQs - http://dss.mo.gov/hie/faq.shtml
  - Web Information Collection Tool - http://www.surveymonkey.com/s.aspx?sm=CAoePG4_2fAOGQFhOKu13_2fvA_3d_3d
  - To express interest in one of the Workgroups, or add your name to the stakeholder database, please contact Charlotte Krebs at ckrebs@primaris.org, or by phone at (573) 424-9174

- **Federal Resources - http://healthit.hhs.gov/portal/server.pt**
  - State HIE Cooperative Agreement Program - http://healthit.hhs.gov/portal/server.pt?open=512&objID=1336&parentname=CommunityPage&parentid=2&mode=2&in_hi_userid=10741&cached=true
  - HIT Extension Program – Regional Centers Cooperative Agreement Program - http://healthit.hhs.gov/portal/server.pt?open=512&objID=1335&parentname=CommunityPage&parentid=3&mode=2&in_hi_userid=10741&cached=true
  - HIT Federal Advisory Committees **–** Agenda and meeting materials will be posted at http://healthit.hhs.gov
  - Health IT Buzz Blog - http://healthit.hhs.gov/blog/onc/
  - AHRQ National Resource Center for Health Information Technology - http://healthit.ahrq.gov

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